ARKANSAS DEPARTMENT OF
Health and Human Services
Division of Child Care & Early Childhood Education

Arkansas Early Childhood Comprehensive Systems Initiative

JOINT MEETING: MEDICAL HOME AND SOCIAL-EMOTIONAL HEALTH WORK GROUPS

Date and Time: November 15, 2005 – 2 to 4:30 p.m.

Members Present: Sherrill Archer, Gil Buchanan, Bruce Cohen, Mary Gaither, Jamie Morrison, Richard Nugent, Ann Patterson, Martha Reeder, Rhonda Sanders, Dan Sullivan, and Paula C. Watson.

Regrets were received from: Patti Bokony, Laura Butler, Deborah Gangluff, Mary Gupton, Betti Hamilton, Anna Huff, Carol A Lee,

The Combined Meeting was chaired by Bruce Cohen and Richard Nugent. – Those in attendance made self-introductions.

Agenda Item #1: Update on QRS Retreat – Martha Reeder

Discussion: Martha Reeder reported on the QRS Retreat, which began about 2 p.m. on Thursday, October 27 and continued to approximately 4 p.m. on Friday, October 28. The sub-group worked on five measures and began the sixth, child/staff ratios. The completed measures are included in the handouts and are listed on the QRS website. The sub-group did not process any of the recommendations from the combined Medical Home and Social Emotional Health Work Groups or from the combined Family Support and Parent Education Work Groups.

Martha stated that what the Medical Home and Social-Emotional Health groups are recommending is groundbreaking. There is nothing to compare it with related to other states. No other states have made specific recommendations about medical home and social-emotional health under a separate measure. This is also true of family support. Most of the time, it is tied into the other measures. What this group is working on has not been addressed specifically in other states.

North Carolina has recently cut their plan back. It is now simple and transparent; but this also creates issues. The QRS group in Arkansas is recommending that the scale be voluntary. If it were mandated, it would need to be legislated.

Most of the other performance measures were obtained by looking at six states that were most like the Arkansas structure. The performance measures for the six states can be reviewed on the website.

The next meeting of the QRS sub-group will be November 29, and the group will resume work on the child/staff ratios measure. Every age group has a different ratio. There is currently no designated ratio at quality-approved sites. Arkansas has one of the highest child-staff ratios of any state. The issue is group size vs. staff. Every age group has a different ratio. Another issue is group size. For example, you have a ratio of 1 – 6 but can never have more than 12 babies with two staff persons in a room.

Agenda Item #1, Continued: Update on QRS Retreat and QRS Concerns

Discussion: Another side is the business side. NAEYC has recommendations related to child/staff ratio. The QRS sub-group is dealing with restrictions that are ruled by the facility that operates the program. Even if the state is able to subsidize the child/staff ratio, the owner/operator may not have room to handle the additional children.

Additional comments made include:

Sherrill Archer stated that ABC has a higher child/staff ratio, 1-10 with no more than 20 in a room. ABC does not include babies.

On Level 1, all the way across the board, a program has to have a regular license without any non-compliance issues on the table. Then they must file a letter of intent to get one star. When they do, they will receive a packet of information. This group might want to include in the packet some things to help the programs down the road with respect to screening, enrolling kids in ARKids, etc. All recommendations must be measurable.

Level 2 is where you start gathering baseline information. Every program has to undergo an outside evaluation, which will most likely be based on the environmental rating scale. At the present time, the system is in place to monitor using the Environmental Rating Scale. If this group is going to recommend an evaluation based on some other criteria, you may want to add an addendum. The ERS may not gather all the information that is wanted.

The question was asked, "Why don't we create a self-assessment tool with questions and get the questionnaire used? Self-assessments raise awareness and give people a sense of what is there. It was suggested that this be done, too. The self-assessment can include the kinds of things you want the programs to do. Attention was called to the fact that at Level 1 there is no feedback. At Level 2 feedback begins. If you want to recommend that a self-assessment be done at Level 2, it must be an efficient system and cost effective. The licensing process is already in place in Level 1.

On Level 2 there will be an Environmental Rating Scale on every program by an outside evaluator. Based on this, then a program improvement plan will be written. This must be done before a program can advance to Level 3. If you want something added to the original baseline, it must be simple and coincide with the ERS and be able to be included as part of their system. The DHHS/DECECE offices are already talking to the data people to make sure all the data fits the system.

Anytime you are entering a monitoring system, there is a cost of at least $200. The more you add to it, the longer it takes. ERS is a standard nationwide system. Centers must commit to doing a self-assessment. Another way to gather the same information, when they decide that they are ready to go to level two, there can be an application. It cannot be a ten-page questionnaire.

Agenda Item #1, Continued: Update on QRS Retreat and QRS Concerns

Discussion: Martha Reeder called to the group's attention that under Learning Environment, Level 2, it mentions, "Child Screening Development." This was not fleshed out in any way.

The question was asked, What is a child portfolio? Sherrill Archer answered as follows—

A child portfolio is a child record that includes information pertinent to that child's familial, financial, developmental, medical/health level or status. It includes information such as but not limited to:

- Family/ personal information such as family makeup, Social Security card, emergency contact, and permission forms.
- Financial information for the family for the purpose of eligibility determination
- Developmental information such as screenings and assessments and examples of the child's work
- Medical/Health information such as screenings and medical diagnosis

The child portfolio moves with the child. It gives a broader picture of the whole child. The health assessment is the immunization part of it. It can be interfaced with the state immunization registry. When the health records are recorded, it is possible that a part of the record will be dumped immediately in the immunization portion. This would require a change in the law. School nurses now have access to immunization records.

From the standpoint of Medical Home, if the assessment only accomplished securing the child's immunization records, the primary care physician, and health insurance status, it would be helpful. The parents provide immunization information to the centers (centers must view it), and facilities are required to make sure immunizations are up-to-date. Licensing checks records only one time in a calendar year even though they visit four times a year.

After QRS looks at the joint recommendations from this group, what else that needs to be done by this group will be determined.

The question was asked, "Are we mixing policies and procedures?" There are two sets of processes being affected. Even though a policy and procedure is set up, the internal processes of those who are monitoring may need to be changed. It was suggested that the group would entertain a recommendation to the Licensing group to check immunizations more often than the present once a year, especially since the centers are routinely checked quarterly.

The recommendations would go into two directions—one to licensing and one to day care centers. There is a need to make sure a child's records are complete.

Bruce Cohen made the statement that a commitment to quality means that there is a way to self-monitor to identify problem areas and opportunity for improvement. Quality is that the organization takes ownership to identify. They are in trouble if they are not reporting honestly or knowing about a problem and not doing anything about it.

Agenda Item #1, Continued: Update on QRS Retreat and QRS Concerns

Discussion: Martha related that there are four steps in the QRS process. First, pinpoint the standards. Step two is accountability. Step three is financing and incentives, and step four is basic informing—educating parents and child care providers. This group has identified good recommendations and we need to hear from the QRS sub-group before making any more changes.

Dick Nugent reaffirmed what has been done by the joint work group members and stated that it does not need to be refined until feedback is available from the QRS group. There are some recommendations that are definitely needed and others are optional.

Next step. Once the recommendations are looked at and selected or turned down, this group will then break down additional steps needed to comply with the selected recommendations. It was noted that there are some tools that are already in place. They will go into a database. Martha Reeder will return with questions on the standards.

Another question: Can a provider say they want to come in at Level 4? The answer: Everything on a Level must be certified before advancing to another Level. It is expected that there will be some items that can be selected from a menu.

Martha Reeder called attention to items in the Learning Environment standard. Under Level 2, the first item relates to choosing from a menu for the 15 hours. On Level 2, some of the training is from the basic level. This group may be able to specify that "X" number of hours be from the Medical Home. This may mean working with vendors to make this happen. The question was asked, "Do people on the Medical Home group have the resources to do the training?" It is possible for some of the group to become members of SPECTRUM by completing the forms to become a trainer. Forms are available from DCCECE.

The next order of business is to finish the state plan in the Medical Home and Social-Emotional Health areas. It is possible that some of the things will roll out in the QRS. There will be a lot of things in the tiers that this group will have to do to provide tools, training, etc. (Training may even be on-line.)

This group needs to decide whether to move into the level of training and become part of SPECTRUM. The group needs to look at different approaches to package materials and tools. There is a need to figure out how to incorporate in what is already being done. Bruce indicated that he had read all of the UCLA materials and one of the things is says is that sometimes you have to start small.

Other questions: How do we get preventive health screens done, and how do we make the referrals happen? Does someone need to coordinate this?

Other statements made: Parents do not take a child to visit the doctor until the child is sick. A lot of the time, the parents are the case managers whether they do it well or badly; they are in control. There are things that need to be done jointly and some things to be done separately.

Agenda Item #1, Continued: Update on QRS Retreat and QRS Concerns
Discussion: Martha Reeder mentioned visiting a SFI Network program with Sherri Jo McLemore, and they interviewed the person on the staff responsible for working with the parents. The staff person called their attention to the fact that you cannot just make a referral to the doctor and make it happen with the parents.
Next meeting date: Tuesday, January 10, 2006, at 2 p.m. at Freeway Medical Center. ? Review Logic Model – Joint Work Groups ? Review QRS Materials There being no further business, the meeting was adjourned.
RESULTING TASKS AND ASSIGNMENTS: Martha Reeder will communicate information about the other states that have filed their plans. Martha Reeder to bring SPECTRUM materials to the meeting